ACC 2.0 Recommendations from the Accountable Care Collaborative: Medicare - Medicaid Program Advisory Subcommittee

May 2016 Update - Includes April 20 PIAC recommendations

Background

The Department of Health Care Policy and Financing (the Department) will be issuing a draft Request for Proposals (RFP) for the Accountable Care Collaborative (ACC) contract re-bid this fall in mid-October, 2016. The final RFP is scheduled for release in May 2017, and new ACC contracts will be in effect by July 1, 2018. This new iteration of the ACC has been the subject of many conversations at the Program Improvement Advisory Committee (PIAC) and the Medicare-Medicaid Program (MMP) Advisory Subcommittee thought it important to participate in the discussion. Given the MMP's particular focus and expertise and the fact that the Department's goal is to include Medicare-Medicaid Enrollees in the ACC once the MMP Demonstration is over, it is imperative that recommendations from the MMP Advisory Subcommittee be considered for this next ACC contract to ensure that the RCCOs/Regional Accountable Entities (RAE's) will serve the MMP community appropriately.

Recommendations were compiled in workgroups represented by MMP Subcommittee members and ad-hoc stakeholders, then vetted by the full MMP Subcommittee. The top-3 MMP specific recommendations for each topic are captured below. For full recommendations, please see the link next to the topic heading.

Topic Areas and Recommendations:

A. Improving RAE Alignment with LTSS Community:

View full recommendation here

1. **LTSS Provider and Consumer Inclusion:** RAEs should be encouraged to include MMP/Medicaid/Waiver beneficiaries, family members, hands-on service providers with Waiver programs, LTSS advocates, providers and related stakeholders willing and able to meet with RAE Governing Boards and Management to address issues of common concern in the delivery of medical care and social services for vulnerable populations; through meeting with management and care teams (where personally identifiable health information is not discussed). RAEs shall report to HCPF/MMP such collaborative activities at least bi-annually. Such inclusion would help assure that person-centered and self-direction, choice and values of respect for this population will be institutionalized among RAEs, medical and social agency providers.

2. **RAE Training by LTSS SMEs:** RAE staff and PCMP providers and staff should participate in trainings on Person-Centered Thinking, Self-Direction, Disability Etiquette, The Dignity of Risk, Cultural Competency and Social Determinants of Health with which the LTSS community has extensive experience/expertise. Independent Living Centers, ADA experts, Colorado Cross

Disability Coalition, SEPs, ADRCs and a range of other disability and social support organizations can provide such In-service Training with expertise in non-clinical topics.

Examples of the many ways the LTSS Community may provide social support services and expertise to RAEs and PCMPs are enumerated in the above *linked* source document.

3. **Hiring Seniors, People with Mental Illness and People with Disabilities:**
   RAE should be encouraged to demonstrate they have made good faith efforts to be inclusive in their staff hiring practices; hiring qualified individuals and parents representing the mosaic of people in each RAE service area so that RAE staff, management and board members may learn first hand from and optimize their understanding of vulnerable, underserved populations, their cultural norms and practices, and social determinants of health issues in their service areas.

B. Care Coordination / Quality:

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1. **Engagement with Providers and Service Agencies in Care Coordination Standards Development** *(Breaking down Silos):*
   RAEs shall/should conduct client-driven community meetings to discuss potential improvements to the **MMP Demonstration Measure Set ('DMS Metrics')** data collection process and results interpretation. Such discussions should including lay stakeholders, Primary Care Medical Providers (PCMP), Behavioral Health, LTSS, LTC providers, families and local community agencies, including but not limited to**:**
   - Aging & Disability Resource Centers (ADRCs)
   - Independent Living Centers (ILCs)
   - Palliative Care/Hospice Providers/Home Health Providers
   - County-based ARCs
   - Single Entry Points (SEPs)
   - County Public Health Departments
   - Community Health Centers (CHCs)
   - Community Centered Boards (CCBs)
   - Acute Care Providers
     - Hospitals, Rehab Facilities, Nursing Homes
     - Emergency Responders (Fire Depts.)
   - Title 5 Organizations

Key Care Coordination strategies that should result in local RAE-specific Care Coordination Standards should include:

a) **Process Flow Maps/Flow Charts:** that define "collaboration" among primary and secondary care providers, including primary responsibilities and care transition processes from one provider or agency to another;
b) **Operating Norms:** for major population cohorts, e.g. seniors, people with mental illness, different Waiver populations, children, school health and welfare programs.
c) **Early Interventions Standards:** should be identified for such population cohorts based on clinical and social service needs.
d) **Norms for Identification of Primary Care Coordinators and Shared Care Plans:** with current contact options provided to clients, family members and service providers for needed services and those available on a 24/7/365 days per week basis.
e) **Definitions of Person-Centeredness:** services and supports that focus on client goals, strengths, capabilities and available resources.
f) **Policies and Procedures:** for resolving primary care responsibilities among medical, BH, LTSS and other required service providers, with a single lead care coordinators identified.
g) **Dealing with uncooperative clients/patients:** including people who refuse to provide information or need individualized training, such as motivational interviewing, and use of Patient Activation Measures.

2. **Each RAEs shall/should establish "Minimum Care Coordination Standards,"** relevant to their local community, identified needs and local circumstances, through discussions with the above community/provider groups, analysis of discrete and high-risk population cohorts utilizing the:

    1) MMP Core Measures *(See Attachment A)*
    2) MMP State-Specific Process Measures, and
    3) MMP State-Specific Demonstration Measures
    4) **Service Care Plans** (**SCPs**) and use of Functional Assessment Standardized Item (ULTC 100.2 replacement) data for those RAEs that collect SCP and FASI data in an electronic format, whereby compiled data reports and analysis are technically feasible.
    5) Impact of the above measures on **Triple Aim** objectives.
    6) Establishing minimum standards to be **the lead care coordination individual;** with **protocols identifying lead roles** when more than on agency is involved.
    7) Focus on **Person-centered Care Coordination** across the above measures and assessment surveys.

3. **RAEs Shall/Should Establish Formal Quality Improvement Projects:** Quality improvement projects should be conducted and reported to HCPF/MMP Subcommittee based on identified problem areas, selected by consensus with community members, providers and agency representatives, with the objective of improving care coordination and quality outcomes using **DMS metrics, SCP** data and the new **FASI** (Functional Assessment Standardized Items -- replacing the ULTC 2.0) on at-risk populations over time. RAEs

shall/should provide the results of their quality improvement processes to community members, providers, HCPF and CMS. DMS metrics, SCP and FASI data should be captured in each RAEs Electronic Health Record when technically feasible to compile all such patient information sources for sharing assessments between RAEs, Ombudsman programs, and patient health portals.

C. Client Engagement:

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1. **Integration with PIAC:** The MMP Demonstration Advisory Committee should operate in ACC 2.0 as a PIAC Committee, charged with: Ensuring the smooth transition of the Demonstration population transitioning into ACC 2.0; monitoring the progress of the FBMME population; and making recommendations from the perspective of the LTSS Community. The Advisory Committee should continue to be comprised of more than 50% beneficiaries, their families and advocates. At least two LTSS clients or their representatives should sit on the PIAC. RAEs ought to include LTSS clients on their local advisory committees.

2. **Outcomes and client satisfaction**: ACC 2.0 quality and outcomes reports ought to include performance, satisfaction and outcomes surveys/metrics for LTSS beneficiaries down to the individual provider level. Clients should be consulted regularly about the operation of ACC 2.0, through focus groups, phone calls and open, public meetings.

3. **Communication with beneficiaries**: People working directly with beneficiaries must be well trained in cultural competency of the populations they serve. People are unlikely to be interested in working with a care manager or anyone else whom they feel does not respect them. As an example, one Demonstration beneficiary described how RCCO personnel would not sit down in her home, and administered the entire SCP while standing. Another described an elderly person who received a call from someone who seemed to have no training on the patience often required in working with elderly people. In addition, people working with clients must understand the possible range of communication issues they may have to address: including limited cell phone minutes, inability to access the internet, language barriers, blindness and a range of **accessibility issues** for people living with disabilities. (See Recommendation E. below) Finally, beneficiaries must have a designated contact person and phone number within each RAE.

D. Client Attribution:

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1. All dual eligible participants expressed concern about potential unintended problems resulting from assignment, especially auto-assignment, of PCMPs. They recommend ACC 2.0 include:
    - Ability of client to keep their preferred physician as their PCMP
    - Right of clients to change PCMPs, even after the 30 day trial period after enrollment,
    - Right of clients to change to a specialist as PCMP when requested by the client
    - No one-year lock-in for clients after they select their PCMP, as this does not meet the Spirit of patient-centered care.
    - The RAE (or RCCO) to be required to assist clients in finding a PCMP when needed

2. To be eligible to receive "auto-assigned" patients, the PCMP should also meet specific requirements such as:
    - Be open to new Medicaid patients (i.e. no wait list).
    - Have a care coordination delegation agreement in place with the RAE.
    - Have national PCMH recognition or meet other TBD nationally recognized practice standards.
    - Meet a minimum threshold of Medicaid patients, or percent of overall practice.

E. Practice Standards:

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1. **RAEs should implement the DCCT Provider Office Accessibility Tool (***Disability Competent Care Tool* or **'DCCT') & DCCT Reporting Matrix over a Staged Period of Time:** RAEs shall/should conduct - or cause to be conducted - surveys of Primary Medical Care Practice (PCMPs) offices accounting for 60% of attributed MMP and traditional Medicaid beneficiaries, within a staged amount of time, under the new ACC 2.0 contracts, using the **DCCT Accessibility Tool** *(Link Here)*

2. **PCMPs should implement (Self-Administered) Cultural Competency Surveys:** RAEs shall/should cause to be conducted **self-administered Cultural Competency Surveys** of all MMP and traditional Medicaid providers in each RAE service area within an agreed upon period of time under the new ACC 2.0 contracts. *(See sample survey options on linked document.)*

3. **Pay-for-Performance Financial Incentives for RAEs and PCMPs should be offered:** for completion of the above two tasks within a specified, staged timeframe with dollar values that start high and diminish over a 12-24 month period of time. (See linked doc. for ADA provider obligations and **tax incentives** for private for-profit practices).

F. Beneficiary Rights and Protections:

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1. The FBMME Committee strongly recommends that the Ombudsman program part of the Demonstration continue in ACC 2.0 and that every ACC enrolled Medicaid beneficiary also have access to an Ombudsman

2. The Ombudsman programs should be adequately funded to operate in ACC 2.0. This is critically important as the Department moves towards payment reform.

3. The Department should work with interested parties including the legal services community, Medicaid beneficiaries and their advocates to establish a uniform set of expectations for grievance and appeals processes in ACC 2.0.

G. Quality Measurement:

1. **Qualitative measures** (e.g. quality-of-life, provider satisfaction) are currently addressed using a mixture of statewide sampling and peer-to-peer interviewing of seniors and people with disabilities, with stakeholder advise by the newly formed **'Community Living Quality Improvement Advisory Group' (CLQIC)**, focused on LTSS/LTC quality.

2. **Perform Sub-Population Comparative Analysis on Key CC Metrics** *(see 'B' above):*
   Sub-population group quality issues should be evaluated and compared among MMP and LTSS Waiver beneficiaries, compared to general Medicaid patients on care coordination and related quality strategies, *using **equivalent comparison groups** and the following quality assessment strategies:*

   a. **Risk Stratification**, based on claims data, Service Coordination Plans (**SCPs**), and new **FASI** (Functional Assessment Standardized Items replacing the ULTC 2.0).
   b. **Targeting** high-risk members, when technically feasible, with new MMIS.
   c. Potential **gaps in care**
   d. Evidence of **health disparities**
   e. **Consumer experience, at the provider level**
   f. **Avoidable** resource utilization, e.g. ambulatory sensitive admissions
   g. Care coordination and care transitions
   h. Developing **evidence-based care coordination, with use of the DMS, SCP, FASI**.

3. **Community Member Engagement - "Quality Performance Advisory Boards:"**
   RAEs shall/should meet with beneficiaries and family members, community interest groups, advocates, personal care attendants, LTSS/LTC providers, hospitals *not less than on a bi-annual basis to discuss gaps in care/services and to:*

   a. *Hear consumer/provider interpretations and discuss care issues – positive as well as those needing focused improvement (See E) below.*
   b. *Assure hospital notification of community agencies immediately upon a Waiver consumers being admitted to an acute care/rehab/SNF facility where social supports are required.*
   c. *Coordinate LTSS services inside hospitals throughout admission of Waiver patients.*
   d. *Develop CC protocols when more than one provider is involved in a patient's care.*

H. PCMP Payments:

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The Advisory Committee recommends that ACC 2.0 incentive payments be clearly tied to both process and performance outcomes as follows:

1. **Measurement:** Quality measures need to be clear, transparent and evidence based. ACC 2.0 should match measures to at-risk population sub-groups. At least some KPIs should reflect the particular needs of LTSS clients. ACC 2.0 should place an emphasis on consistent and transparent data that tracks Key Performance Indicators (KPI) over time to allow for sustainable improvement. Any KPI being considered should be directly tied to decreasing cost, improving outcomes, and enhancing the member experience. As an example of current practice, at least some providers feel that the focus is on performance on administrative measures, for example completing assessments as opposed to quality process and outcome measures.

2. **Payment:** Incentive payments to providers should be tied to individual performance with their patients, rather than overall RAE performance. ACC 2.0 should provide an enhanced PMPM for PCMPs who meet nationally recognized criteria (i.e. NCQA PCMH, National Quality Foundation, National Core Indicator surveys, Disability Competent Care etc.), have a delegation agreement in place with their RAE or meet standards proving they are committed to quality provision of care to LTSS clients or other MME clients.

3. **Coordination:** Providers should not be expected to adhere to multiple different measures across public and private payers. KPI and other accountability measures should align with those used in other Colorado innovation projects. As an example, measures for the FBMME population should align with Medicare. Colorado should integrate successes from payment reform projects already in progress.

I. Transition to ACC Phase II:

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The MMP Advisory Committee recommends that the transition between the Demonstration and ACC 2.0 include the following:

1. **Best Practices:** Incorporate best practices developed through the Demonstration into ACC 2.0 - see for example Advisory Committee Comments on Continuity of Care and Care Coordination. The Demonstration has developed a number of innovative approaches to care coordination, care management and ensuring accessibility. Not only should the specific needs of this very high needs community be addressed going forward, but lessons learned from working with those that are among the most vulnerable should benefit the entire Medicaid community. The Demonstration will have served little purpose if its successes are not adopted for the entire Medicaid population and particularly if they do not continue to benefit MME enrollees.

2. **No gap in services:** Ensure there are no gaps in ACC services and that transitions between the Demonstration and ACC2ACC 2.0 are monitored on a client specific basis by the RAEs.

3. **Monitoring and Participation: The Committee recommends the Demonstration Advisory Committee turn in to a formal Committee of the PIAC.** In this way the particular needs of the MME community will be addressed through the transition and beyond. In addition, the Advisory Committee recommends that the PIAC add two seats for MME beneficiaries and the Department and the PIAC receive regular reports from the Ombuds programs and the RAEs regarding Grievances and Complaints, with an emphasis on more regular reporting during the transition period.

J. Behavioral Health Integration:

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1. Cleary define behavioral health Integration

In April 2013, the National Integration Academy Council released the Lexicon for Behavioral Health and Primary Care Integration prepared for the Agency for Healthcare Research and Quality (AHRQ) (hereinafter, the Lexicon).[i] The Lexicon is a set of concepts and definitions developed by expert consensus to provide a practical definition for behavioral health and primary care integration. This consensus Lexicon enables effective communication and concerted action among clinicians, care systems, health plans, payers, researchers, policymakers, business modelers, and patients working for effective, widespread implementation on a meaningful scale. The Lexicon aligns with and adds to existing resources by focusing on key functions at the intersection of behavioral health and primary care.

While the Lexicon is focused on primary care integration, its broad definition can encompass the range of integrated care efforts underway in Colorado:

"The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."[ii]

This range of integration approaches fit the state's redesign efforts for ACC 2.0 as well as other state work (e.g. SIM, PRIME).

Each RAE will be allowed to determine the payment approach for behavioral health integration (see recommendation #2). However, there are three key functions, further explained below, that must be addressed within the contract in service to integration.

1. **Target Population:** Primary care practices will have a mechanism in place to consistently identify patients with behavioral health need. Practices can choose from any of the following:

    - Depression;
    - Anxiety; and,
    - Substance and drug use

    Non-proprietary Measures appropriate to these conditions are:

    - PHQ-9;
    - GAD-7; and,
    - AUDIT/DAST, respectively.

    These conditions can be tied to Key Performance Indicators (KPIs).

2. **Integration Setting:** In accordance to the above definition, integration can happen in either primary care or mental health settings (e.g. primary care integrates behavioral health, mental health centers bring on primary care).

3. **Approach to Integrate:** How practices choose to integrate care must be open to them. Each RAE may adopt an approach they wish to pursue consistent with the definition. A plan must be clearly articulated as to what the approach will be for integration. If the practice has a plan to augment onsite provision with technology, that should be made explicit in their overall proposal.

    Of note: Integrating care is different than coordinating care though integration requires coordination. Integrating care is much more about point of care access to an evidence based behavioral health intervention, which can be delivered in whatever way is most aligned with the primary care practice workflow. RAE's should not confuse integration with coordination.

2. *Create a payment model supportive of integrated behavioral health*

Ideally paying practices a global budget for their integration would best support all integration efforts. Evidence suggests that paying primary care for the behavioral health provider may be more helpful in adopting integrated approaches than having behavioral health simply bill out a code on their own. The principles for such a payment include:

Payment to the practice will be sufficient to cover the cost of the behavioral health provider;

The payment is not to the behavioral health provider, but the practice; and,

The payment, while either FFS or APM will serve the same function to allow for onsite behavioral health.

There are current examples of this working well in the state that could be scaled. For example, the 1281 pilot through Rocky (PRIME) could be used as an example for payment reform.

If a specific population is needed to be targeted for payment reform, it makes sense for the "duals" to be this population as they often have some of the most pressing behavioral health needs, which are exacerbated by payment, policy, and access issues. To this end, RAE's may consider paying a PMPM to the practice that is inclusive of behavioral health to allow for instantaneous access to behavioral health services in primary care. The primary or secondary diagnosis should not be the determining factor in where a patient receives their behavioral health care; however, a patient's choice should be considered throughout the process.

3. Adopt competencies for behavioral health clinicians working in primary care

In November of 2015, Colorado stakeholders contributed to development of eight core competencies for behavioral health providers working in primary care during a consensus conference. The consensus conference and competencies development was supported by five Colorado foundations, and the Colorado SIM leadership team. Stakeholders from across the state, including primary care and behavioral health providers, payers, policy makers, educators, and foundation program officers, were invited to participate in the process of creating these competencies.

These competencies were built off a robust literature and evidence base. They take the best thinking and evidence around competencies and organize them in such a way that they can be used by Colorado practices, including those participating in SIM.

It is recommended that all RAE's working to integrate adopt these competencies as a standard for behavioral health clinicians working in primary care settings. The eight competencies are as follows:

1. Identify and assess behavioral health needs as part of a primary care team

2. Engage and activate patients in their care

3. Work as a primary care team member to create and implement care plans that address behavioral health factors

4. Help observe and improve care team function and relationships

5. Communicate effectively with other providers, staff, and patients

6. Provide efficient and effective care delivery that meets the needs of the population of the primary care setting

7. Provide culturally responsive, whole-person and family-oriented care

8. Understand, value, and adapt to the diverse professional cultures of an integrated care team

A more detailed report of the competencies can be found here: http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf

While assessing these competencies can be at the discretion of the RAE, it is important to have a standard for what is expected of behavioral health in primary care to ensure as much success as possible through integration.

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[i] Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013.

[ii] Ibid.